a. Total Medicaid patient revenues (TMPR) paid to the hospital for patient services under a state plan plus the amount of the cash subsidies (CS) directly received from state and local governments, divided by the total net revenues (TNR) (charges, minus contractual allowances, discounts etc.) For patient services plus the cash subsidies, and;

b. The total amount of the hospital's charges for patient services attributable to charity care (CC) (care provided to individuals who have no source of payment, third-party or personal resources) less cash subsidies directly received from state and local governments in the same period, divided by the total amount of the hospital's charges (THC) for patient services. The total patient charges attributed to charity care shall not include any contractual allowances and discounts other than for indigent patients not eligible for medical assistance under a State Plan.

$$LIUR = \frac{TMPR + CS}{TNR + CS} + \frac{CC - CS}{THC}$$

3. As determined from the third prior year desk-reviewed cost report, the hospital has either -

(a) An unsponsored care ratio of at least ten percent (10%). The unsponsored care ratio is determined as the sum of bad debts and CC divided by TNR and also meets either of the criteria in paragraph VI.A.2.; or

(b) The hospital ranks in the top fifteen (15) in the number of Medicaid inpatient days provided by that hospital compared to Medicaid patient days provided by all hospitals, and the hospitals also have a Medicaid nursery utilization ratio greater than thirty-five percent (35%) as computed by dividing Title XIX nursery and neonatal days by total nursery and neonatal days.

(c) The facility operated a neonatal intensive care unit with a ratio of Missouri Medicaid neonatal patient days to Missouri Medicaid total patient days in excess of the percentage identified in 13 CSR 70-15.010 (6) as reported or verified by the division from the third prior year cost report;

4. As determined from the third prior year desk reviewed cost report, the hospital has -

   (a) An unsponsored care ratio of at least sixty-five percent (65%); or

   (b) The hospital is owned or operated by the Board of Curators as defined in Chapter 172, RSMo and the Missouri Rehabilitation Center created by Chapter 199, RSMo or their successors.

5. As determined from the third prior year desk reviewed cost report, hospitals which annually provide more than five thousand (5,000) Title XIX days of care and whose Title XIX nursery days represent more than fifty percent (50%) of the hospital's total nursery days.

B. Those hospitals which meet the criteria established in paragraphs (VI) (A)l., 2. and 4. shall be deemed first tier ten percent (10%) Add-on disproportionate share hospital (DSH). Those hospitals which meet the criteria established in (VI)(A)l. and 3. shall be deemed first tier DSH. Those hospitals which meet only the criteria established in paragraphs (VI)(A)l. and 2. shall be deemed Second Tier DSH.

C. Disproportionate Share Hospital Rates will be determined as follows:

1. Data from the most recently desk-reviewed cost report for the latest fiscal period preceding the rate determination date will be used to determine a rate in accordance with the following formula subjected to the adjustments described in paragraph VI.C.1. (c).

$$\text{Per Diem Rate} = \frac{OC}{MPD} + \frac{CMC}{MPDC}$$

   (a) OC-the operating component is the hospital's total allowable cost less CMC. Only the operating component will be increased by the trend indices for the current and first prior fiscal year.

   (b) CMC-the capital and medical education components of the hospital's total allowable cost;

   (c) MPD-the number of Medicaid inpatient billed days for service dates in the applicable cost report period;

   (d) MPDC - MPD as defined previously with a minimum utilization of sixty percent as described in paragraph V.C.4; and

   (e) An additional increase of ten percent (10%) will be added to the rate if the facility is first tier ten percent (10%) Add-on.

2. First tier disproportionate share hospitals shall be exempt from length of stay limits except as they apply to GR recipients. Allowable days for claim payment will be the medically necessary billed days of service for which the patient was Medicaid-eligible.

3. All estimated disproportionate share payments for each hospital determined as the product of the applicable disproportionate share rate per subsection VI.C. times allowable days for claim payment per agency determination will be compared against the minimum payment amounts per federal regulations. The disproportionate share will not be subject to the Medicare rate limitation.

   (a) The federal minimum payment per-diem rate, not to exceed the Medicare rate will be the general plan per-diem plus a percentage determined as the greater of -

      (1) One-half (½) the amount by which the provider's Medicaid inpatient utilization rate, as described in subparagraph VI.A.2.(b)(1), exceeds the sum of the state's mean Medicaid inpatient utilization rate plus one (1) standard deviation; or

      (2) Two and one-half percent (2.5%)

   (b) The federal minimum payment amount for the facility will be determined as the product of the federal minimum payment per-diem rate, as established in subparagraph VI.C.3 (a), times the allowable days for claim payment per program benefit limitations as determined by the Division of Medical Services.

   (c) If the federal minimum payment amount in subparagraph VI.C.3.(b) exceeds the disproportionate share payments as determined in paragraph VI.C.3. the provider's Missouri Medicaid disproportionate share per diem rate shall be adjusted to a level at which the federal minimum payment amount equals the rate multiplied by the applicable number of days.

4. Hospitals shall not send amended cost reports or other data necessary for qualification for disproportionate share classification for purposes of rate reconsideration unless the reports or other necessary data are received within sixty (60) days of the date of the division's notification of the final determination of the rate.

5. Disproportionate share hospitals which qualify as first tier ten percent (10%) add-

D. OBRA 93 Limitation. In accordance with OBRA 93, disproportionate share payments shall not exceed one hundred percent (100%) of the unreimbursed cost for Medicaid and the cost of the uninsured. The OBRA 93 Limitation shall be computed using the third prior year desk reviewed cost report trended thru the State Fiscal Year and adjusted for MC+ implementation as defined in Section (18). If the sum of disproportionate share payments exceeds the estimated OBRA 93 limitation, the difference shall be deducted in order as necessary from safety net payment, other disproportionate share lump sum payments, and if necessary, as a reduced per diem.

E. Hospital which qualified as disproportionate share for SFY 94 and which failed to requalify as disproportionate share for SFY 95 shall be granted disproportionate share status effective January 1, 1995. Disproportionate share status shall be at the same level (Tier I or Tier 11) which the hospital qualified for during SFY 94. This waiver shall not continue for any admissions after June 30, 1995.

VII.A. Effective for admissions beginning on or after July 11 1991, outlier adjustments for medically necessary inpatient services involving exceptionally high cost or exceptionally long lengths of stay for Missouri Medicaid-eligible children under the age of six (6) will be made to disproportionate share hospitals, and for Missouri Medicaid-eligible infants under the age of one (1) will be made to any other Missouri Medicaid hospital.

1. The following criteria must be met for the services to be eligible for outlier review:

   (a) Services must have been provided in a hospital which is eligible to receive outlier adjustments;

      (1) the hospital must have qualified as a disproportionate share status under Section VI of this plan and the patient was a Missouri Medicaid eligible child under the age of six (6) for all dates of services presented for review; or

      (2) the patient must be a Missouri Medicaid eligible infant under the age of one (1) year for all dates of services presented for review; and

   (b) one of the following conditions must be satisfied:

      (1) the total reimbursable charges for dates of service as described in subparagraph VII.A.1.(a) must be at least one hundred fifty percent (150%) of the sum of total third party liabilities and Medicaid inpatient claim payments for said claim; or

      (2) the dates of service must exceed sixty (60) days and less than seventy-five percent (75%) of the total service days were reimbursed by Medicaid.

2. Claims for all dates of services eligible for outlier review must:

(a) have been submitted to the Division of Medical Services' fiscal agent in their entirety for routine claims processing and claims payments must have been made before the claims are submitted to the Division for outlier review; and

(b) be submitted for outlier review with all documentation as required by the Division of Medical Services no later than ninety (90) days for the last payment made by the fiscal agent through the normal claims processing system for those dates of services.

3. The claims will be reviewed for:

(a) medical necessity at an inpatient hospital level of care;

(b) appropriateness of services provided in connection with the diagnosis; and

(c) charges that are not permissible per the Division of Medical Services' policies established in the institutional manual and hospital bulletins.

4. After the review, reimbursable costs for each claim will be determined using the following data from the most recent Medicaid hospital cost report filed by April 1 of each year or the cost report filed for the fiscal period in which the admission occurred if earlier:

(a) average routine (room and board) costs for the general and special care units for all days of the stay eligible per the outlier review; and

(b) ancillary cost to charge ratios applied to claim ancillary charges determined eligible for reimbursement per the outlier review.

(c) no cost will be calculated for items such as malpractice insurance premiums, interns and residents, professional services, or return on equity.

5. Outlier adjustment payments for each hospital will be made during June of each State fiscal year for all claims submitted by March 1 which satisfies all conditions in paragraph VII.A.l., VII.A.2., and VII.A.3. of each fiscal year. The payments will be determined for each hospital as follows:

   (a) sum all reimbursable costs per paragraph VII.A.4. for all applicable outlier claims to equal total reimbursable costs.

   (b) subtract third party payments and Medicaid payments for said claims from total reimbursable costs to equal excess cost.

   (c) multiply excess costs by 50%.

B. Effective for admissions beginning on or after July 1, 1997, outlier adjustments shall also be made for Missouri Medicaid recipients enrolled in MC+. Claim charges and Medicaid payment data will be determined from encounter data provided by the MC+ Health Plan provider.

VIII. Payment Assurance

A. The state will pay each hospital, which furnishes the services in accordance with the requirements of the State Plan, the amount determined for services furnished by the hospital according to the standards and methods set forth in the regulations implementing the Hospital Reimbursement Program.

B. Where third party payment is involved, Medicaid will be the payor of last resort with the exception of State Programs such as Vocational Rehabilitation and the Bureau for Special Health Care Needs. Procedures for remitting third party payments are provided in the Missouri Medical Assistance Program Provider Manuals.

When the Missouri Medicaid agency determines the existence of third party liability at the time a claim is filed, the agency rejects the claim and returns it to the provider for a determination of the amount of liability. When the amount of liability is determined, Medicaid then pays the claim to the extent that payment allowed under Missouri Medicaid's payment schedule exceeds the amount of the third party's payment.

For inpatient hospital services provided for an individual entitled to Medicare Part A benefits and eligible for Medicaid, Medicaid's payment will be limited to the lower of Medicare's coinsurance and deductible amounts or the amount Medicaid's payment schedule exceeds Medicare's payment.

C. Regardless of changes of ownership, management, control, operation, leasehold interests by whatever form for any hospital previously certified for participation in the Medicaid program, the department will continue to make all the Title XIX payments directly to the entity with the hospital's current provider number and hold the entity with the current provider number responsible for all Medicaid liabilities.

IX. Provider Participation

Payments made in accordance with the standards and methods described in this attachment are designed to enlist participation of a sufficient number of hospitals in the program, so that eligible persons can receive the medical care and services included in the State Plan at least to the extent these services are available to the general public.

X. Payment in Full

Participation in the program shall be limited to the hospitals who accept, as payment in full for covered services rendered to Medicaid recipients, the amount paid in accordance with the regulations implementing the hospital reimbursement program.

XI. Plan Evaluation

Documentation will be maintained to effectively monitor and evaluate experience during administration of this plan amendment.

XII. Inappropriate Placements

A. The hospital per-diem rates as determined under this plan and in effect on October 1, 1981, shall not apply to any recipient who is receiving inpatient hospital care when he is only in need of nursing home care.

1. If a hospital has an established ICF/SNF or SNF only Medicaid rate for providing nursing home services in a distinct part setting, reimbursement for nursing home services provided in the inpatient hospital setting shall be made at the hospital's ICF/SNF or SNF only rate.

2. If a hospital does not have an established Medicaid rate for providing nursing home services in a distinct part setting, reimbursement of nursing home services provided in the inpatient hospital setting shall be made at the state swing bed rate.

3. No Medicaid payments will be made on behalf of any recipient who is receiving inpatient hospital care and is not in need of either inpatient or nursing home care.

XIII. Out-of-State and In-State Federally-Operated Hospital Reimbursement

A. Effective for admissions beginning after April 1, 1994, inpatient services for Missouri Medicaid recipients age twenty-one (21) or older in hospitals located outside Missouri and federally-operated hospitals located within Missouri will be reimbursed at the lower of--

1. The charges for those services; or

2. The individual recipient's days of care (within benefit limitations) multiplied by the Title XIX per-diem rate of three hundred forty-five dollars and thirteen cents ($345.13).

B. Effective for admission beginning after April 1, 1994, inpatient services for children under the age of twenty-one (21) in hospitals located outside Missouri will be reimbursed at the lower of--

1. The charges billed for those services; or

2. The individual recipients days of care (within benefit limitations) multiplied by the Title XIX per-diem rate established by the host state's Medicaid agency. If the host state does not reimburse inpatient hospital services on a per-diem basis, the per-diem rate shall be six hundred sixty dollars and eight-nine cents ($660.89). The inpatient psychiatric limitation (section 15) shall apply.

C. There will be no adjustments or exemptions to this per-diem rate and no individual rate reconsideration will be performed.

D. Payments on claims submitted, unless otherwise specified, constitute final payment to hospitals located outside the state of Missouri and to federally-operated hospitals within the state of Missouri on those claims and no year-end cost settlements will be done. Therefore, these hospitals are not required to file Medicaid cost reports with the state of Missouri.

XIV. Reimbursement for inpatient hospital services associated with an admission for the surgical performance of only those human organ and bone marrow transplantations as defined in Attachment 3.1-E is made on the basis of reasonable cost of providing the services as defined and determined by the Division of Medical Services.

The methodology defined in this attachment in sections I. through XIV. for all other inpatient hospital services reimbursement is not applicable to these specific services. Inpatient hospital costs associated with these services are excluded from the per-diem reimbursement rate computation.

XV. RESERVED

XVI. Safety Net Adjustment. A Safety Net Adjustment shall be provided for each hospital which qualified as disproportionate share under the provision of VI.A.4. prior to the end of each state fiscal year.

A. The Safety Net Adjustment for the federal fiscal year (FFY) shall be computed as follows:

1. The safety net adjustment shall be computed as three-quarters of the Medicaid Add-On payment described in section XVII for the SFY ending on June 30th prior to the end of the FFY on September 30th and one-quarter of the Medicaid Add-On payments for the SFY ending on June 30th after the end of the FFY.

2. If the aggregate cash subsidies (CS) are less than the matching amount required, the total aggregate safety net adjustment will be adjusted downward accordingly, and distributed to the hospitals in the same proportions as the original safety net adjustments.

3. The data sources, reports and data definitions for determining the Safety Net Adjustments shall be the same as described in paragraph VI.A.2. and adjusted as maybe described above. Hospitals which do not have a third prior fiscal year cost report described in paragraph VI.A.2. shall not be eligible for a safety net adjustment. No amended cost reports shall be accepted after the Division's annual determination of the adjustment amount.

4. Adjustments provided under this section shall be considered reasonable costs for purpose of the determinations described in paragraph V.D.2.

XVII. In accordance with state and federal laws regarding reimbursement of inpatient and outpatient hospital services and the implementation of a Medicaid managed care system, reimbursement for state fiscal year 1997 (July 1, 1996 - June 30, 1997) shall be determined as follows.

A. State Fiscal Year 1997 Reimbursement for Inpatient and Outpatient Hospital Services

1. Claims for inpatient and outpatient hospital services for Missouri Medicaid eligible recipients, not enrolled in a Medicaid managed care plan such as MC+, shall continue to be reimbursed in accordance with current regulations and claims processing procedures.

2. Inpatient per diem rates in effect as of June 30, 1996, shall be adjusted by one-half of the trend indices applicable for state fiscal year 1995, 1996, and 1997. Per diem rates for hospitals which initially qualify July 1, 1996, as first or second tier Disproportionate Share or hospitals which previously qualified as first or second tier and failed to requalify July 1, 1996 shall be adjusted to a disproportionate share or general plan level as appropriate.

3. Medicaid Add-on payments based on one hundred percent (100%) of the allocated Medicaid shortfall and ninety-nine percent (99%) of the cost of the uninsured shall be prorated over SFY 97. Hospitals which contribute through a plan approved by the director of health to support the state's poison control center and the Primary Care Resource Initiative for Missouri (PRIMO) shall receive a Medicaid Add-on payment based on one hundred percent (100%) of the allocated Medicaid shortfall and one hundred percent (100%) of the cost of the uninsured.

B. Medicaid Add-Ons

1. Medicaid Add-Ons for Shortfall and Uninsured are based on the estimated inpatient and outpatient cost attributable to Medicaid and the cost of the Uninsured for SFY 97 less the estimated per diem and outpatient reimbursement for SFY 97. The Add-on payments for cost of the Uninsured are not considered in the determination of inpatient recoupments described in section V.D.2.

2. The estimated inpatient cost for SFY 97 is based on the desk reviewed base year cost per day, trended thru SFY 97, and multiplied by the estimated inpatient days for SFY 97. The estimated outpatient cost is based on the base year outpatient cost trended thru SFY 97. The base year is the third prior fiscal year (i.e., the base year for SFY 97 is the FY 94 cost report). The trending used to approximate SFY 97 costs shall include a utilization adjustment to account for the increased per diem cost resulting from introduction of MC+. The utilization adjustment shall be phased-out as follows: Year 1 (First full year of MC+) - 100%; Year 2 - 67%; and Year 3 - 33%. If applicable, an initial partial year payment will be made if MC+ is in effect less than a full state fiscal year. The phase-out will then be Year 2 - 100%; Year 3 - 67%; and Year 4 - 33%.

3. The estimated per diem reimbursement for SFY 97 is based on the current per diem rate multiplied by the inpatient days, with benefit limitations, estimated to be paid for SFY 97. The estimated outpatient reimbursement is based on payment at ninety percent (90%) of base year cost trended thru SFY 97.

4. An adjustment to recognize the FRA assessment not included in the desk reviewed cost per day is also included. The FRA assessment attributable to Medicaid and Uninsured is determined by multiplying the ratio of base year Medicaid and Uninsured days to total inpatient days by the SFY 97 FRA assessment.

5. An adjustment shall also be determined for hospitals which operated a poison control center during the base year and which continues to operate a poison control center in a Medicaid managed care region. The Add-On adjustment shall reimburse the hospital for the prorated Medicaid managed care cost in accordance with the allocation formula described in the Allocation of Medicaid Add-Ons section; and

6. The Add-On payment for the cost of the uninsured is determined by multiplying the charges for charity care and allowable bad debts by the hospital's total cost-to-charge ratio from the base year cost report's desk review. The cost of the uninsured is then trended to the current year. Allowable bad debts do not include the costs of caring for patients whose insurance covers the particular service, procedure or treatment; and

C. Allocation of Medicaid Add-Ons.

1. Medicaid Add-Ons determined for Medicaid shortfall and cost of the Uninsured shall be allocated based on the estimated effect of implementation of an MC+ except as noted in paragraph XVII.C.3. in accordance with this section. Medicaid per-diem and outpatient payments, which are paid on a claim-specific basis do not require an allocation.

2. Except as noted in paragraph XVII.C.3. Medicaid Add-Ons shall be multiplied by a managed care allocation factor which incorporates the estimated percentage of the hospitals Medicaid population which will remain outside a managed care system and the estimated implementation date for a managed care system. For example: If a hospital has 1) an annual Add-On payment of $100,000, 2) 40% of their Medicaid days are related to Medicaid recipients not eligible for Medicaid managed care, and 3) the projected implementation date for managed care is October 1, 1995; the prorated Medicaid Add-On is $55,000 [($100,000 25%) + ($100,000 75% 40%)].

3. The Medicaid Add-On shall not be allocated as described in paragraph XVII.C.2., therefore shall include a payment related to MC+ Medicaid the following:

   A. The FRA assessment related to MC+; and
   B. The Utilization Adjustment related to MC+; and
   C. For First Tier DSH Hospitals only, any Medicaid Add-Ons related to MC+;
   D. The Utilization and First Tier adjustment shall be phased-out as follows: Year 1 (First full year of MC+) - $100%; Year 2 - 67%; and Year 3 - 33%. If applicable, an initial partial year payment will be made if MC+ is in effect less than a full state fiscal year. The phase-out will then be Year 2 - 100%; Year 3 - 67%; and Year 4 - 33%.

XVIII. Medicaid GME Add-On -- A Medicaid Add-On determined for Graduate Medical Education (GME) costs shall be allocated based on the estimated effect of implementation of a Medicaid managed care system such as MC+ in accordance with this section.

A. The Medicaid GME Add-On for Medicaid clients covered under a Managed Care Plan shall be determined using the base year cost report and paid in quarterly installments. The base year cost report shall be the third prior fiscal year (i.e., the base year for SFY 1997 is the FY 1994 cost report). The hospital per diem shall continue to include a component for GME related to Medicaid clients not included in a managed care system.

1. Total GME cost shall be multiplied by a managed care allocation factor which incorporates the estimated percentage of the hospital's Medicaid population included in a managed care system and the estimated implementation date for a managed care system. For example: If a hospital has 1) an annual GME cost of one hundred thousand dollars ($100,000), 2) forty percent (40%) of their Medicaid days are related to Medicaid recipients eligible for Medicaid managed care, and 3) the projected implementation date for managed care is October 1, 1995; the prorated GME Add-On is thirty thousand dollars ($30,000).

2. The annual GME Add-On shall be paid in quarterly installments.

XIX. Hospital Mergers. Hospitals that merge their operations under one Medicare and Medicaid provider number shall have their Medicaid reimbursement combined under the surviving hospital's (the hospital's whose Medicare and Medicaid provider number remained active) Medicaid provider number.

1. The Disproportionate share status of the merged hospital provider shall be:

   A. The same as the surviving hospital's status was prior to the merger for the remainder of the State Fiscal Year in which the merger occurred; and

   B. Determined based on the combined desk reviewed data from the appropriate cost reports for the merged hospitals' in subsequent fiscal years.

2. The per diem rate for merged hospitals shall be calculated:

   A. For the remainder of the State Fiscal Year in which the merger occurred by multiplying each hospital's estimated Medicaid paid days by its per diem rate, summing the estimated per diem payments and estimated Medicaid paid days, and then dividing the total estimated per diem payments by the total estimated paid days to determine the weighted per diem rate. The effective date of the weighted per diem rate will be the date of the merger; and

   B. For subsequent State Fiscal Years based on the combined desk review data after taking into account the different fiscal years ends of the cost reports.

3. The Medicaid Add-On for shortfall and uninsured shall be:

   A. Combined under the surviving hospital's Medicaid provider number for the remainder of the State Fiscal Year in which the merger occurred; and

   B. Calculated for subsequent State Fiscal Years based on the combined date from the appropriate cost report for each facility.

XX. Medicaid and Uninsured Add-Ons for State Fiscal Year 1998.

A. Section XVII describes the Medicaid and Uninsured Add-Ons paid to hospitals for SFY 97. Those payments shall continue on a prorated basis, except as noted in subsection XX.B., as an estimate for SFY 98 reimbursement until September 30, 1997, or until such time as a state plan amendment modifying the payments is effective.

B. An Adjustment to the SFY 97 Add-Ons shall be made based on the full year effect of MC+ implementation and for the change in phase-out percentage as provided in section XVII.

INSTITUTIONAL STATE PLAN AMENDMENT
ASSURANCE AND FINDING CERTIFICATION STATEMENT

STATE: Missouri TN - 97-15

REIMBURSEMENT TYPE: Inpatient hospital X

PROPOSED EFFECTIVE DATE: August 5, 1997

A. State Assurances and Findings. The State assures that is has made the following findings:

1. 447.253 (b) (1) (i) - The State pays for inpatient hospital services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards. _____

2. With respect to inpatient hospital services - -

   a. 447.253 (b) (1) (ii) (A) - The methods and standards used to determine payment rates take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs. _____

   b. 447.253 (b) (1) (ii) (B) - If a state elects in its State plan to cover inappropriate level of care services (that is, services furnished to hospital inpatients who require a lower covered level of care such as skilled nursing services or intermediate care services) under conditions similar to those described in section 1861 (v) (1) (G) of the Act, the methods and standards used to determine payment rates must specify that the payments for this type of care must be made at rates lower than those for inpatient hospital level of care services, reflecting the level of care actually received, in a manner consistent with section 1861 (v) (1) (G) of the Act. _____

   If the answer is "not applicable," please indicate:

   _____

c. 447.253 (b) (1) (ii) (C) - The payment rates are adequate to assure that recipients have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality. _____

4. 447.253 (b) (2) - The proposed payment rate will not exceed the upper payment limits as specified in 42 CFR 447.272:

a. 447.272 (a) - Aggregate payments made to each group of health care facilities (hospitals, nursing facilities, and ICFs/MR) will not exceed the amount that can reasonably be estimated would have been paid for those services under Medicare payment principles. _____

b. 447.272 (b) - Aggregate payments to each group of State-operated facilities (that is, hospitals, nursing facilities, and ICFs/MR) - - when considered separately - - will not exceed the amount that can reasonably be estimated would have been paid for under Medicare payment principles. _____

If there are no State-operated facilities, please indicate "not applicable:"

_____

c. 447.272 (c) - Aggregate disproportionate share hospital (DSH) payments do not exceed the DSH payment limits at 42CFR 447.296 through 447.299.

d. Section 1923 (g) _ DSH payments to individual providers will not exceed the hospital-specific DSH limits in section 1923(g) of the Act. _____

B. State Assurances. The State makes the following additional assurances:

1. For hospitals - -

a. 447.253 (c) - In determining payment when there has been a sale or transfer of the assets of a hospital, the State's methods and standards provide that payment rates can reasonably be expected not to increase in the aggregate solely as a result of changes of ownership, more than payments would increase under Medicare under 42 CFR 413.130, 413.134, 413.153 and 413.157 insofar as these sections affect payment for depreciation, interest on capital -indebtedness, return on equity)if applicable), acquisition costs for which payments were previously made to prior owners, and the recapture of depreciation.

3. 447.253 (e) - The State provides for an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues as the State determines appropriate, of payment rates. _____

4. 447.253 (f) - The State requires the filing of uniform cost reports by each participating provider. _____

5. 447.253 (g) - The State provides for periodic audits of the financial and statistical records of participating providers. _____

6. 447.253 (h) - The State has complied with the public notice requirements of 42 CFR 447.205.

Notice published on: Provided previously

If no date is shown, please explain:

_____

_____

_____

7. 447.253 (i) - The State pays for inpatient hospital services using rates determined in accordance with the methods and standards specified in the approved State plan. _____

C. Related Information

1. 447.255 (a) - NOTE: If this plan amendment affects more than one type of provider (e.g., hospital, NF, and ICF/MR; or DSH payments) provide the following rate information for each provider type, or the DSH payments. You may attach supplemental pages as necessary.

Provider Type: Hospital

For hospitals: The Missouri Hospital Plan includes DSH payments in the estimated average rates. However, the DSH payments included in the estimated average rates do not represent the total DSH payments made to hospitals under the Missouri Medicaid Plan.

Estimated average proposed payment rate as a result of this amendment:
$ 752.90

Average payment rate in effect for the immediately preceding rate period:
$ 752.90

2. 447.255 (b) - Provide an estimate of the short-term and, to the extent feasible, long-term effect the change in the estimated average rate will have on:

(a) The availability of services on a statewide and geographic area basis: This amendment will not effect the availability of short-term or long-term services.

(b) The type of care furnished: This amendment will not effect hospital services furnished to Medicaid eligibles.

(c) The extent of provider participation: This amendment will assure recipients have reasonable access taking into account geographic location and reasonable travel time to inpatient hospital services.

(d) For hospitals - - the degree to which costs are covered in hospitals that serve a disproportionate number of low income patients with special needs: It is estimated that disproportionate share hospitals will receive 100% of its Medicaid cost for low income patients with special needs.